Interview Structure

**\*\*\*\*Always be using the Interview Techniques when appropriate**

1. Opening
   1. Introducing yourself and greeting the patient properly (proper name)
   2. Be seated properly
   3. Comment that you will be taking notes
   4. Begin Rapport building
2. Chief complaint
   1. “So \_\_\_\_\_\_\_ what brings you to the office today?”
3. History of Present Illness (*Open 🡪 Closed Questions*)
   1. Symptom
      1. Location
         1. Where is the….
      2. Quality
         1. How does the pain feel? Describe it for me?
      3. Severity
         1. How would you grade your pain? Worst imaginable or mediocre? 1- 10?
      4. Radiation
         1. Does the pain spread anywhere?
      5. Onset
         1. When did this start happening? What were you doing?
      6. Duration
         1. How long does it usually last?
      7. Frequency
         1. How often does this happen?
      8. Provocation and Exacerbation
         1. Does anything seem to precede the pain that may provoke it?
         2. What makes it worse?
      9. Relief/ alleviation
         1. Does anything make the pain feel better?
      10. Associated Symptoms
          1. Do you notice any pain or anything strange anywhere else while this is going on?
   2. Patient Perspective
      1. How has this affected the normal everyday stuff you usually do?
      2. What do you think it is?
4. Allergies
   1. Agent
   2. Reaction
5. Medications
   1. Prescription
      1. Name
      2. Route
      3. Dose
      4. Frequency
   2. Any other supplements, over the counter, etc
   3. Alcohol
      1. Type and frequency
   4. Tobacco
      1. Type and frequency
   5. Illicit/ recreational drugs
      1. Type and frequency
6. Past pertinent History
   1. Childhood illnesses
   2. Adult
      1. Hospitalizations and others
      2. Surgeries
      3. Ob/gyn
         1. Menstruation Periods
      4. Physicals, immunizations, & Regular exams
      5. Psychiatric (Depression Anxiety)
7. Family History
   1. Illness in the family
8. Personal/ Social History
   1. Occupation
   2. Diet and exercise
   3. Personal interests
   4. Spirituality
9. Closing
   1. Summarize
   2. Ask if the patient has anything to add or say
   3. Let them know what is going to happen next in the process